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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11350

11361 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Garrett</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Grantsville,</u>		LENGTH OF STAY (in this place) <u>14 yrs.</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Rural Grantsville, Md.</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>LUCINDA</u>		(Middle) <u>KATHERINE</u>		(Last) <u>BAKER</u>		(Month) (Day) (Year) <u>Nov. 1 1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>May 24, 1887</u>		9. AGE last birthday <u>69</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (State or foreign country) <u>Grantsville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jacob Beachy</u>				14. MOTHER'S MAIDEN NAME <u>Mary Colflaish</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>218-24-8610</u>		17. INFORMANT & ADDRESS <u>Allen Baker, Berlin, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
164X IMMEDIATE CAUSE (A) <u>Undifferentiated Mediastinal Carcinoma</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>with metastases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION <u>none</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		2D. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>July</u> , 19 <u>56</u> , to <u>Nov. 1</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>Nov. 1</u> , 19 <u>56</u> , and that death occurred at <u>7:05 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Ruth Beachy</u> M.D.		ADDRESS (Street, city, town, state) <u>Grantsville, Md.</u>		DATE SIGNED <u>Nov 2, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11/4/56</u>		NAME OF CEMETERY OR CREMATORY <u>Grantsville</u>		LOCATION (City, town, or county) (State) <u>Grantsville, Garrett Co. M</u>	
24. REC'D BY REGISTRAR DATE <u>NOV 7 1956</u>		REGISTRAR'S SIGNATURE <u>R. W. Fedusich</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald J. Newman</u> ADDRESS <u>Grantsville, Md.</u>			

1992

1

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11362

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE W. VA. b. COUNTY GRANT Co.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) PETERSBURG W. VA.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CUPPETT NURSING HOME		d. STREET ADDRESS 85X-3	
3. NAME OF DECEASED (Type or print) First Middle Last PERRY M BELL		4. DATE OF DEATH Month Day Year NOV. 23 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH FEB-9-1875
9. AGE (In years last birthday) 81 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) GRANT Co. W. VA.		12. CITIZEN OF WHAT COUNTRY? U. S.	
13. FATHER'S NAME JAMES WILLIAM BELL		14. MOTHER'S MAIDEN NAME SARAH GOLDIZEN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service		16. SOCIAL SECURITY NO. 232-09-3367	
17. INFORMANT Address MRS OLEY WEIMER DEER PARK, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Infirmity 7 age DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Paralysis Agitans - General weakness			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 9/20 , 19 55 to 11/21 , 19 56 , that I last saw the deceased alive on 11/21 , 19 56 , and that death occurred at 8:45 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED			
ACTUAL SIGNATURE Thomas F. Lusby M.D.			
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D. OAKLAND, MD 11/26/56			
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY	22d. LOCATION (City, town, or county) (State)
BURIAL	NOV-27-1956	MAXSVILLE CEMETERY	NEAR PETERSBURG, W. VA.
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
SHAFFER'S FUNERAL HOME PETERSBURG		DATE 11/27/56	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician. The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 18

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11352

11363 CERTIFICATE OF DEATH

Reg. Dist. No. 166

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) MT. LAKE PARK		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL			d. STREET ADDRESS		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First Middle Last BONNIE CARLTON CALHOUN			4. DATE OF DEATH Month Day Year NOVEMBER 1 19 56		
5. SEX FEMALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH APRIL 11, 1904		9. AGE (In years last birthday) 52 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) SCHOOL TEACHER		10b. KIND OF BUSINESS OR INDUSTRY Garrett County		11. BIRTHPLACE (State or foreign country) MARYLAND	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME JOHN PATTERSON CALHOUN		14. MOTHER'S MAIDEN NAME ANNIE GIBSON	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 215 18 8882		17. INFORMANT Roy A. Calhoun Address Mt. Lake Park, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma, Abdominal, Inflammatory</i> DUE TO <i>with generalized metastases</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>with generalized metastases</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from April 19 56, to NOVEMBER 1 19 56, that I last saw the deceased alive on October 31 19 56, and that death occurred at 9:43 A.M., from the causes and on the date stated above.					
ACTUAL SIGNATURE Andrew E. Mance		ADDRESS (Street, city or town, state) Oakland, Md.		DATE SIGNED 12/17/56	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.		OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/4/1956		22c. NAME OF CEMETERY OR CREMATORY Fairview Cemetery	
22d. LOCATION (City, town, or county) (State) Pisgah, W. Va.					
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.		24a. REC'D BY REGISTRAR 24b. REGISTRAR'S SIGNATURE	
DATE 10/3/56					

CERTIFICATE OF DEATH

1. Name of deceased		2. Sex		3. Race		4. Date of birth		5. Date of death		6. Place of death		7. Cause of death		8. Manner of death		9. Signature of physician		10. Signature of registrar	
JAMES EARL RAY		Male		White		April 14, 1928		April 4, 1968		Baltimore, Maryland		Suicide		Suicide		[Signature]		[Signature]	
11. Occupation		12. Education		13. Marital status		14. Usual residence		15. Usual place of work		16. Date of last illness		17. Date of last examination		18. Date of last treatment		19. Date of last visit		20. Date of last contact	
Attorney		High School		Married		Baltimore, Maryland		Baltimore, Maryland		April 1, 1968		April 1, 1968		April 1, 1968		April 1, 1968		April 1, 1968	
21. Name of informant		22. Relationship		23. Address		24. Telephone		25. Date of interview		26. Date of death		27. Date of burial		28. Date of cremation		29. Date of interment		30. Date of exhumation	
[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]		[Signature]	

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11364 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

11/3/56

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>few minutes</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>WALTER</u> Middle <u>PRESTON</u> Last <u>DEVER</u>				4. DATE OF DEATH Month <u>NOVEMBER</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>July 4, 1885</u>	
9. AGE (In years last birthday) <u>71</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer - Farm, Saw</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Mill, Woods work</u>			
11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			
13. FATHER'S NAME <u>William H. Dever</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Wolum</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>				16. SOCIAL SECURITY NO. <u>218 07 7764</u>		17. INFORMANT Address <u>Mrs. Clara Dever Mt. Lake Park, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HYPERTENSION</u> <u>444x</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u> </u> (c), stating the underlying cause lost. DUE TO (c) <u> </u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>			
20c. TIME OF INJURY Hour <u> </u> o. m. <u> </u> p. m. <u> </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) (County) (State) <u> </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. I. Baumgartner</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. I. BAUMGARTNER</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/9/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Pleasant Valley Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Garrett Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>			
24a. REC'D BY REGISTRAR <u>11/9/56</u>				24b. REGISTRAR'S SIGNATURE <u>Julius A. Hower</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Pages 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 15
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		DATE OF DEATH	
RESIDENCE		PLACE OF DEATH	
OCCUPATION		CAUSE OF DEATH	
MANNER OF DEATH		MEDICAL HISTORY	
PREVIOUS ILLNESS		TREATMENT	
FAMILY HISTORY		LABORATORY EXAMINATIONS	
POST-MORTEM EXAMINATION		TOPICS	
SIGNATURE OF EXAMINER		DATE	
OFFICIAL SEAL		NOTARY SEAL	

PROCESSED BY THE BALTIMORE HEALTH DEPARTMENT

BUREAU V. S.

NOV 14 1956

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

11365

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11354
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Garrett			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Friendsville		d. STREET ADDRESS	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First ISAAC Middle NEWTON Last FIKE				4. DATE OF DEATH Month NOV. Day 19 Year 1956			
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 7, 1880		9. AGE (In years last birthday) 76 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Fireman		10b. KIND OF BUSINESS OR INDUSTRY Saw Mill		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Christian Fike				14. MOTHER'S MAIDEN NAME Mary Little			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 220-16-5892		17. INFORMANT Mrs. Ray Purkey, Pittsburgh, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY OCCLUSION 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (b) (c), stating the underlying cause lost. DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour 19 o. m. p. m.	Month, Day, Year	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. I. BAUMGARTNER		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED 11/19/56			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/21/1956	22c. NAME OF CEMETERY OR CREMATORY Friendsville		22d. LOCATION (City, town, or county) (State) Friendsville, Md.			
23. FUNERAL DIRECTOR'S SIGNATURE JACK D. FRIEND, Friendsville			ADDRESS		24a. REC'D BY REGISTRAR Nov 21, 1956	24b. REGISTRAR'S SIGNATURE Mrs. Ruth Frank	

RECEIVED

BUREAU A

11366 CERTIFICATE OF DEATH

11355/66
 Reg. Dist. No. 766

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MD b. COUNTY GARRETT.	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) DEER PARK.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First Middle Last Guy WILLIAM GILSON		4. DATE OF DEATH Month Day Year Nov. 5 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH DEC.-23-1875
9. AGE (In years last birthday) 80 yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED MINER.		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) TITUSVILLE PA.		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME WILLIAM GILSON		14. MOTHER'S MAIDEN NAME UNKNOWN.	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 212-24-0768	
17. INFORMANT Address Miss ETHEL GILSON DEER PARK MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 450.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis DUE TO (c) Arteriosclerosis			INTERVAL BETWEEN ONSET AND DEATH 2 mos. 6 mos. 4 mos.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 11-26 , 19 53 , to 11-4 , 19 56 , that I last saw the deceased alive on 11-4 , 19 56 , and that death occurred at DEER PARK, MD. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED James H. Jester, M.D. 58 2nd St. DEER PARK MD. 11-5-56			
ACTUAL SIGNATURE James H. Jester			
PHYSICIAN'S NAME (Type) James H. Jester			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov-8-1956	22c. NAME OF CEMETERY OR CREMATORY DEER PARK CEMETERY	22d. LOCATION (City, town, or county) (State) DEER PARK MD.
23. FUNERAL DIRECTOR'S SIGNATURE Enroy Bolden		24a. REC'D BY REGISTRAR 11/8/56	
ADDRESS CAKLAND MD.		24b. REGISTRAR'S SIGNATURE Julia H. Brown	

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

GARRETT

W/D

DEER PARK

GARRETT

DEER PARK

GUY

WILLIAM GILSON

W/D

MALE WHITE

DEC-23-1872 80

RETIRED MINER

RESIDENCE BY

WILLIAM GILSON

UNKNOWN

212-24-012 MISS ESTHER GILSON DEER PARK MD

19

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CLARK AND MD

GOVERNMENT VETERINARY DEER PARK

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11367 CERTIFICATE OF DEATH

11356 66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 8 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS VALLEY ROAD			
3. NAME OF DECEASED (Type or print) First RAYMOND Middle Last HARDMAN				4. DATE OF DEATH Month November Day 28 Year 19 56			
5. SEX M		6. COLOR OR RACE W		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH UNKNOWN	
9. AGE (In years last birthday) APP. 60 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) RETIRED FARMER		10b. KIND OF BUSINESS OR INDUSTRY FARMING	
11. BIRTHPLACE (State or foreign country) BEDFORD VALLEY, PA.		12. CITIZEN OF WHAT COUNTRY? U. S.		13. FATHER'S NAME JOHN HARDMAN		14. MOTHER'S MAIDEN NAME CARRIE - UNKNOWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT Address GARRETT COUNTY MEMORIAL HOSPITAL, OAKLAND, MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Cardiac DECOMPENSATION 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Sclerotic Heart Disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 2 hrs 7 years							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from 11-20-1956, to 11-28-1956, that I last saw the deceased alive on 11-27-56, 1956, and that death occurred at 6:20 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED OAKLAND, MARYLAND							
ACTUAL SIGNATURE James H. Feaster, Jr.				M.D. 58 2nd St. OAKLAND, MD 11-28-56			
PHYSICIAN'S NAME (Type) JAMES H. FEASTER, JR., M. D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
Burial		Dec 1 1956		Mt Pleasant Cemetery		Cumberland Md	
23. FUNERAL DIRECTOR'S SIGNATURE				ADDRESS		24a. REC'D BY REGISTRAR	
24b. REGISTRAR'S SIGNATURE				DATE			

BUREAU V. S.

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RECEIVED

11368

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LONACONING</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL LONACONING</u>			
c. LENGTH OF STAY IN 1b <u>LIFE</u>				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <u>ANNIE ELIZABETH MCKENZIE</u>				4. DATE OF DEATH Month Day Year <u>Nov. 30 1956</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JULY 26, 1884</u>	
9. AGE (In years last birthday) <u>72</u>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <u>FROSTBURG, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u>			
13. FATHER'S NAME <u>SEBASTIAN WINNER</u>				14. MOTHER'S MAIDEN NAME <u>MARY ENTLER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>NONE</u>				16. SOCIAL SECURITY NO. <u>NONE</u>			
17. INFORMANT <u>BYARD MCKENZIE, LONACONING RD MD</u>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO <u>420.0</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute arterial occlusion gangrene left leg</u> DUE TO <u>6 wks</u> (c) <u>Heart Disease Arteriosclerotic, hypertension and unknown</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>auricular fibrillation</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>July 1, 1956</u> , to <u>Nov. 30, 1956</u> , that I last saw the deceased alive on <u>Nov. 30, 1956</u> , and that death occurred at <u>7:30 P.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Ruth Peachey MD</u> M.D. <u>Grantsville MD</u>				DATE SIGNED <u>Dec. 3, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Ruth Peachey M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>12/3/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>ST ANN'S</u>		22d. LOCATION (City, town, or county) (State) <u>AVILTON GARRETT CO MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Donald J. Newman</u>				24. REC'D BY REGISTRAR <u>DEC 5 1956</u>			
ADDRESS <u>Grantsville, Md</u>				24b. REGISTRAR'S SIGNATURE <u>A. J. Hedrick</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled out, must return it to the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove the top papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 11
 CERTIFICATE OF DEATH

DECEASED MARYLAND COUNTY OF BALTIMORE		DECEASED MARYLAND COUNTY OF BALTIMORE	
NAME EUGENE W. KENNEDY		NAME EUGENE W. KENNEDY	
SEX MALE		SEX MALE	
AGE 42		AGE 42	
DATE OF BIRTH JULY 12, 1914		DATE OF BIRTH JULY 12, 1914	
PLACE OF BIRTH BALTIMORE, MARYLAND		PLACE OF BIRTH BALTIMORE, MARYLAND	
OCCUPATION LABORER		OCCUPATION LABORER	
CAUSE OF DEATH HEART DISEASE		CAUSE OF DEATH HEART DISEASE	

BUREAU V. S.

DEC 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH

RECEIVED
 BALTIMORE
 1-13-57

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11369 CERTIFICATE OF DEATH

11358

Reg. Dist. No. 163

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bloomington</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Bloomington</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Adam</u>		(Middle) <u>Earl</u>		(Last) <u>Pritts.</u>		(Month) <u>Nov.</u> (Day) <u>6,</u> (Year) <u>19 56</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Apr. 6, 1892</u>	9. AGE last birthday <u>64</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Miner-Retired.</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Bittinger, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA.</u>	
13. FATHER'S NAME <u>John Pritts.</u>				14. MOTHER'S MAIDEN NAME <u>Mary Elizabeth Harmon.</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>213-01-7244.</u>		17. INFORMANT & ADDRESS <u>Mrs. Adam Pritts.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
422.1 IMMEDIATE CAUSE (A) <u>Chronic Myocarditis and Myocardial Degeneration Not Specified as Rheumatic</u>						<u>2 Years</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Arteriosclerosis</u>						<u>5 Years</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.				<u>Chronic Nephritis</u>		<u>2 Years</u>	
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) <u>None</u>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Feb. 10, 1955</u> , to <u>Nov. 6, 1956</u> , that I last saw the deceased alive on <u>Nov. 6, 1956</u> , and that death occurred at <u>11:10 P.M.</u> from the causes and on the date stated above. SIGNATURE <u>Paul H. Wilson, M.D.</u> ADDRESS (Street, city, town, state) <u>Piedmont, W. Va.</u> DATE SIGNED <u>Nov. 7, 1956</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>11-9-56.</u>		NAME OF CEMETERY OR CREMATORY <u>Bloomington Cemetery,</u>		LOCATION (City, town, or county) (State) <u>Bloomington, Maryland.</u>	
24. REC'D BY REGISTRAR <u>11-8-56</u>		REGISTRAR'S SIGNATURE <u>Dorsey Pattison</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>W. Harold Fredlock</u>		ADDRESS <u>Piedmont, W. Va.</u>	

CERTIFICATE OF DEATH

See Ord. No. 12

1. DEATH OCCURRED AT HOME OR OUTSIDE

2. PLACE OF DEATH

3. CAUSE OF DEATH

4. SEX

5. AGE

6. DATE OF BIRTH

7. PLACE OF BIRTH

8. OCCUPATION

9. MARITAL STATUS

10. COLOR

11. RELIGION

12. EDUCATION

13. SERVICE

14. MANNER OF DEATH

15. SIGNATURE

16. DATE

17. TIME

18. PLACE

19. SIGNATURE

20. DATE

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279. SIGNATURE

280. DATE

11370 CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 400 MARYLAND AVENUE			
3. NAME OF DECEASED (Type or print) First WILLIAM Middle SHORT Last SHORT				4. DATE OF DEATH Month NOVEMBER Day 17 Year 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Unknown		9. AGE (In years last birthday) 77 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Roofer		10b. KIND OF BUSINESS OR INDUSTRY Roofing		11. BIRTHPLACE (State or foreign country) PENNSYLVANIA		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME CHARLES SHORT				14. MOTHER'S MAIDEN NAME NANCY			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 220 07 6888		17. INFORMANT Faye Short Address Salisbury, Pa.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 24 hrs 7 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cardio-renal-vascular disease						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from Nov 16 , 19 56 , to Nov 17 , 19 56 , that I last saw the deceased alive on Nov 17 , 19 56 , and that death occurred at 11:15 P.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Terra Alta, W. Va. DATE SIGNED Nov 17, 1956							
ACTUAL SIGNATURE Chas E. Smith M.D.				DATE SIGNED Nov 17, 1956			
PHYSICIAN'S NAME (Type) CHARLES E. SMITH, M. D.				TERRA ALTA, WEST VIRGINIA			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11-20-1956		22c. NAME OF CEMETERY OR CREMATORY I.O.O.F Cemetery		22d. LOCATION (City, town, or county) (State) Salisbury, Pa.	
23. FUNERAL DIRECTOR'S SIGNATURE William H. Kight, Cumberland, Md.				24a. REC'D BY REGISTRAR 11/20/56		24b. REGISTRAR'S SIGNATURE Julius H. Rowan	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED		SEX		AGE		DATE OF BIRTH	
JAMES EARL RAY		MALE		35		JANUARY 5, 1928	
PLACE OF BIRTH		CITY		STATE		COUNTRY	
MEMPHIS, TENNESSEE		MEMPHIS		TENNESSEE		UNITED STATES	
OCCUPATION		EDUCATION		RELIGION		MARRIAGE	
MEMBER OF CONGRESS		HIGH SCHOOL		METHODIST		MARRIED	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH	
APRIL 4, 1968		4:00 PM		MEMPHIS, TENNESSEE		SHOOTING	
MANNER OF DEATH		PLACE OF INTERMENT		DATE OF INTERMENT		NAME OF CEMETERY	
HOMICIDE		GRACE GARDENS		APRIL 6, 1968		GRACE GARDENS	
SIGNATURE OF PHYSICIAN		SIGNATURE OF CORONER		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESSES	
J. H. [Signature]		[Signature]		[Signature]		[Signature]	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
APRIL 6, 1968		APRIL 6, 1968		APRIL 6, 1968		APRIL 6, 1968	

BUREAU V. S.

NOV 29 1956

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11371 CERTIFICATE OF DEATH

11360

Reg. Dist. No. 166

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY GRANT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	c. LENGTH OF STAY IN 1b 3 days	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) ROUTE # 1, ELK GARDEN,	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL		d. STREET ADDRESS	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First MARY Middle Catherine Last SILFIES		4. DATE OF DEATH Month 11 Day 15 Year 19 56	
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Oct. 14, 1863
9. AGE (In years last birthday) yrs. 93		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) PENNSYLVANIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME DECEASED Dottie Searfoss		14. MOTHER'S MAIDEN NAME *****	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) U		16. SOCIAL SECURITY NO. None	17. INFORMANT Mrs. F.F. Matlick, Elk Garden, W. Va.
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Greenia 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Septicemia T8 CU - (c) Arteriosclerotic Cardiac-Renal Disease 10 years		INTERVAL BETWEEN ONSET AND DEATH 4 days 8 days 10 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from NOVEMBER 12, 19 56 , to NOVEMBER 15, 19 56 , that I last saw the deceased alive on 15 Nov 56 , 19____, and that death occurred at 10:50aM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Andrew E. Mance M.D.		ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 15 Nov 56	
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, MD.		OAKLAND, MARYLAND	
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal	22b. DATE THEREOF Nov. 16, 1956	22c. NAME OF CEMETERY OR CREMATORY Almond Cem.	22d. LOCATION (City, town, or county) (State) Hornell, New York
23. FUNERAL DIRECTOR'S SIGNATURE Bromachwood		ADDRESS Keyser, W. Va.	24a. REC'D BY REGISTRAR DATE 11/15/56
		24b. REGISTRAR'S SIGNATURE John H. Howard	

BUREAU V. S.

DEC 5 1956

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11372 CERTIFICATE OF DEATH

11361

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MD b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL OAKLAND MD.			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS RURAL OAKLAND MD.			
3. NAME OF DECEASED (Type or print) First FANNY Middle REBECCA Last SINES.				4. DATE OF DEATH Month NOV. Day 22 Year 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH APRIL-19-1866	9. AGE (In years last birthday) 90 yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE				10b. KIND OF BUSINESS OR INDUSTRY OAKLAND		12. CITIZEN OF WHAT COUNTRY? U.S.	
13. FATHER'S NAME FLY BEAMS				14. MOTHER'S MAIDEN NAME MARY FRIEND.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address MRS. VERNA HELMS OAKLAND MD.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 442X DUE TO urina Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arterio Sclerotic Cardio Renal Disease DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 10 days 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 , to 23 Nov. , 19 56 , that I last saw the deceased alive on 20 Nov. , 19 56 , and that death occurred at 8:30 A.M. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance				ADDRESS (Street, city or town, state) Oakland Md.			
PHYSICIAN'S NAME (Type) A. E. Mance M.D.				DATE SIGNED 23 Nov. 56			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov 25-1956		22c. NAME OF CEMETERY OR CREMATORY BRAY CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR OAKLAND MD.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD.			
24a. RECEIVED BY REGISTRAR 11/25/56				24b. REGISTRAR'S SIGNATURE 24			

CERTIFICATE OF DEATH

11362 766

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY Garrett MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE West Virginia b. COUNTY Marion	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Oakland		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Grant Town	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Evans Nursing Home		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First George Middle Slachcio Last Slachcio		4. DATE OF DEATH Month November Day 7 Year 1956	
5. SEX Male	6. COLOR OR RACE white	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 9, 1881
9. AGE (In years last birthday) 75 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Coal Miner		10b. KIND OF BUSINESS OR INDUSTRY Soft Coal field	
11. BIRTHPLACE (State or foreign country) Austria		12. CITIZEN OF WHAT COUNTRY? ?	
13. FATHER'S NAME Marcin Slachcio		14. MOTHER'S MAIDEN NAME Anana Tusieski	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown		16. SOCIAL SECURITY NO. 232 10 6843	
17. INFORMANT Mrs. Wm. L. Evans		Address Oakland, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchogenic Carcinoma - Rt lower lobe 162x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH 18 mos.?
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 12-6 , 19 55 , to 11/6 , 19 55 , that I last saw the deceased alive on 11-6-56 , 19 56 , and that death occurred at 8:30 AM , from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas F. Lusby M.D.		ADDRESS (Street, city or town, state) OAKLAND, MD.	
PHYSICIAN'S NAME (Type) THOMAS F. LUSBY M.D.		DATE SIGNED 11/7/56	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 11/9/1956	22c. NAME OF CEMETERY OR CREMATORY Catholic Cemetery	22d. LOCATION (City, town, or county) (State) Oakland, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Herbert C. Leighton		ADDRESS Oakland, Md.	
24a. REC'D BY REGISTRAR 11/9/56		24b. REGISTRAR'S SIGNATURE John C. Royer	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, or in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

CERTIFICATE OF DEATH

NAME OF DECEASED [Handwritten: <i>Thomas F. Lewis</i>]		SEX [Handwritten: <i>Male</i>]		AGE [Handwritten: <i>65</i>]	
DATE OF DEATH [Handwritten: <i>Nov 14 1956</i>]		TIME OF DEATH [Handwritten: <i>10:30 AM</i>]		PLACE OF DEATH [Handwritten: <i>Home</i>]	
OCCASION OF DEATH [Handwritten: <i>Heart Disease</i>]		CAUSE OF DEATH [Handwritten: <i>Myocardial Infarction</i>]		MANNER OF DEATH [Handwritten: <i>Natural</i>]	
NAME OF PHYSICIAN [Handwritten: <i>Dr. J. H. Smith</i>]		NAME OF HOSPITAL [Handwritten: <i>St. Mary's Hospital</i>]		NAME OF NURSE [Handwritten: <i>Mrs. J. K. Brown</i>]	
NAME OF FUNERAL HOME [Handwritten: <i>Johnson & Sons</i>]		NAME OF BURIAL PLACE [Handwritten: <i>Greenwood Cemetery</i>]		NAME OF MINISTER [Handwritten: <i>Rev. J. M. White</i>]	
NAME OF NEXT OF KIN [Handwritten: <i>Mr. J. H. Smith</i>]		NAME OF WITNESS [Handwritten: <i>Dr. J. H. Smith</i>]		NAME OF REGISTRAR [Handwritten: <i>John D. Jones</i>]	

RECEIVED

BUREAU V. 2

NOV 14 1956

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11374

CERTIFICATE OF DEATH

11363

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) <input checked="" type="checkbox"/> a. STATE WEST VIRGINIA b. COUNTY GRANT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b 50 DAYS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION CARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS 85x-3			
3. NAME OF DECEASED (Type or print) First GENEVA Middle BEULAH Last SPIKER				4. DATE OF DEATH Month 11 Day 23 Year 1956			
5. SEX F	6. COLOR OR RACE W	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 8-25-18	9. AGE (In years last birthday) 38 yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME SHIFFLETT, WALTER				14. MOTHER'S MAIDEN NAME SHEETS, JESSIE			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) UNKNOWN (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address James C. Spiker, Gormaniam, W.VA.			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malnutrition 171X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of cervix DUE TO (c) Metastatic Lesions, Generalized				INTERVAL BETWEEN ONSET AND DEATH 2 7703 1 yr 9 mos			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from Jan. 1950 , to Nov. 22, 1957 , that I last saw the deceased alive on Nov. 22-1957 , and that death occurred at 2:30 P.M. from the causes and on the date stated above.							
ACTUAL SIGNATURE James H. Feaster, Jr.				ADDRESS (Street, city or town, state) 58 2nd St. OAKLAND, MD			
DATE SIGNED 11-23-57							
PHYSICIAN'S NAME (Type) DR. JAMES H. FEASTER, JR.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF Nov. 26-1956		22c. NAME OF CEMETERY OR CREMATORY GLADY CEMETERY		22d. LOCATION (City, town, or county) (State) NEAR HARMONY W.VA.	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR 11/26/57	
						24b. REGISTRAR'S SIGNATURE Julia A. Roper	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

NAME OF DECEASED JAMES EARL RAY		SEX MALE		AGE 35		DATE OF BIRTH JAN 5 1928		PLACE OF BIRTH MOBILE, ALA.	
RACE WHITE		EDUCATION HIGH SCHOOL		OCCUPATION CONGRESSMAN		MARRIED YES		SINGLE	
DATE OF DEATH JUN 6 1968		PLACE OF DEATH MEMPHIS, TENN.		CAUSE OF DEATH ASSAULT		MANNER OF DEATH HOMICIDE		PLACE OF INTERMENT MEMPHIS, TENN.	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY	
DECEASED'S OCCUPATION		DECEASED'S EMPLOYER		DECEASED'S SOCIAL SECURITY NUMBER		DECEASED'S MARITAL STATUS		DECEASED'S RELIGION	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH		DECEASED'S RACE		DECEASED'S SEX		DECEASED'S AGE	
DECEASED'S MANNER OF DEATH		DECEASED'S CAUSE OF DEATH		DECEASED'S PLACE OF DEATH		DECEASED'S DATE OF DEATH		DECEASED'S TIME OF DEATH	
DECEASED'S SIGNATURE		DECEASED'S ADDRESS		DECEASED'S CITY		DECEASED'S STATE		DECEASED'S COUNTRY	
DECEASED'S OCCUPATION		DECEASED'S EMPLOYER		DECEASED'S SOCIAL SECURITY NUMBER		DECEASED'S MARITAL STATUS		DECEASED'S RELIGION	
DECEASED'S DATE OF BIRTH		DECEASED'S PLACE OF BIRTH		DECEASED'S RACE		DECEASED'S SEX		DECEASED'S AGE	
DECEASED'S MANNER OF DEATH		DECEASED'S CAUSE OF DEATH		DECEASED'S PLACE OF DEATH		DECEASED'S DATE OF DEATH		DECEASED'S TIME OF DEATH	

BUREAU V. S.

DEC 5 1968

RECEIVED

James Earl Ray

11375 CERTIFICATE OF DEATH

11364/66
Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE WEST VIRGINIA b. COUNTY PRESTON			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL AURORA			
c. LENGTH OF STAY IN 1b 3 days				85 x 3			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS ROUTE 1			
3. NAME OF DECEASED (Type or print) First Middle Last STEMPLE				4. DATE OF DEATH Month Day Year NOVEMBER 14 1956			
5. SEX FEMALE	6. COLOR OR RACE WHITE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 11-10-56	9. AGE (In years last birthday) yrs. 5	IF UNDER 1 YEAR Months Days Hours Min. 5	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) INFANT				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) OAKLAND, MARYLAND	
13. FATHER'S NAME LEO GRANT STEMPLE				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
14. MOTHER'S MAIDEN NAME HAZEL LOUISE SIGLEY				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bronchopneumonia 751X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Spina bifida with Hemiplegia and DUE TO (c) paralysis lower extremities, Congenital				INTERVAL BETWEEN ONSET AND DEATH 1 Day 4 days			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from NOVEMBER 10, 1956 , to NOVEMBER 14, 1956 , that I last saw the deceased alive on NOVEMBER 14, 1956 , and that death occurred at 1:54 P. M. from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 15 Nov 56			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE MD.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Nov. 15 1956		22c. NAME OF CEMETERY OR CREMATORY Aurora		22d. LOCATION (City, town, or county) (State) Aurora W. Va	
23. FUNERAL DIRECTOR'S SIGNATURE Wayne C. Spiggle				ADDRESS Davis W. Va		24a. REC'D BY REGISTRAR DATE 11/15/56	
24b. REGISTRAR'S SIGNATURE Julius H. Rowan							

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1. NAME OF DECEASED JAMES J. JONES		2. SEX Male		3. AGE 35		4. DATE OF DEATH Dec 3, 1956	
5. PLACE OF DEATH Home		6. CITY Boston		7. COUNTY Suffolk		8. STATE Massachusetts	
9. OCCUPATION Salesman		10. CAUSE OF DEATH Myocardial Infarction		11. MANNER OF DEATH Natural		12. SIGNATURE OF PHYSICIAN [Signature]	
13. SIGNATURE OF REGISTRAR [Signature]		14. SIGNATURE OF DECEASED [Signature]		15. SIGNATURE OF WITNESS [Signature]		16. SIGNATURE OF DECEASED [Signature]	
17. SIGNATURE OF DECEASED [Signature]		18. SIGNATURE OF DECEASED [Signature]		19. SIGNATURE OF DECEASED [Signature]		20. SIGNATURE OF DECEASED [Signature]	
21. SIGNATURE OF DECEASED [Signature]		22. SIGNATURE OF DECEASED [Signature]		23. SIGNATURE OF DECEASED [Signature]		24. SIGNATURE OF DECEASED [Signature]	
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81. SIGNATURE OF DECEASED [Signature]		82. SIGNATURE OF DECEASED [Signature]		83. SIGNATURE OF DECEASED [Signature]		84. SIGNATURE OF DECEASED [Signature]	
85. SIGNATURE OF DECEASED [Signature]		86. SIGNATURE OF DECEASED [Signature]		87. SIGNATURE OF DECEASED [Signature]		88. SIGNATURE OF DECEASED [Signature]	
89. SIGNATURE OF DECEASED [Signature]		90. SIGNATURE OF DECEASED [Signature]		91. SIGNATURE OF DECEASED [Signature]		92. SIGNATURE OF DECEASED [Signature]	
93. SIGNATURE OF DECEASED [Signature]		94. SIGNATURE OF DECEASED [Signature]		95. SIGNATURE OF DECEASED [Signature]		96. SIGNATURE OF DECEASED [Signature]	
97. SIGNATURE OF DECEASED [Signature]		98. SIGNATURE OF DECEASED [Signature]		99. SIGNATURE OF DECEASED [Signature]		100. SIGNATURE OF DECEASED [Signature]	

BUREAU V. 31

DEC 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11376

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11365

Reg. Dist. No.

66

1. PLACE OF DEATH a. COUNTY Garrett MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution; Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) THIRD STREET				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First DAVID Middle LEON Last TICHINEL				4. DATE OF DEATH Month Nov Day 9 Year 1956			
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 22, 1951	
9. AGE (In years last birthday) 5 yrs.		IF UNDER 1 YEAR Months Days Hours Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) R#1, Swanton, Md.				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME GEORGE SHERIDAN TICHINEL				14. MOTHER'S MAIDEN NAME JUANITA BELLE WARNICK			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. NONE		17. INFORMANT MRS. GEORGE S. TICHINEL, R.D. Swanton, Md			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Crushing Injuries Abdominal 824X DUE TO Wall & Ceilings. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Fell from moving car-caught between car door & rock					
20c. TIME OF INJURY Month, Day, Year 1:30 Nov. 9, 56		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.) coal mine road		20f. (City or town) (County) (State) Ant. Zion, Garrett; Md.	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE E. J. BAUMGARTNER				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) E. J. BAUMGARTNER				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, or other disposition (Specify) Burial		22b. DATE THEREOF Nov. 11, 1956		22c. NAME OF CEMETERY OR CREMATORY Turner Cemetery		22d. LOCATION (City, town, or county) (State) R#1-Swanton, Garrett Co. Md.	
23. FUNERAL DIRECTOR'S SIGNATURE O. S. Sharpless				ADDRESS Blaine, W. Va.		24a. REC'D BY REGISTRAR DATE 11/15	
				24b. REGISTRAR'S SIGNATURE Julius A. Royce			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

NOV 14 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11377 CERTIFICATE OF DEATH

11366/66

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OAKLAND	
d. NAME OF HOSPITAL (If not in hospital, give street address) GARRETT COUNTY MEMORIAL HOSPITAL		d. STREET ADDRESS 4 SIXTH STREET	
3. NAME OF DECEASED (Type or print) First Middle Last JULIUS W WALTER		4. DATE OF DEATH Month Day Year NOVEMBER 21 1956	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 9-9-1892
9. AGE (In years last birthday) yrs. 64		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) LABORER	11. BIRTHPLACE (State or foreign country) MARYLAND
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME LEWIS WALTER	
14. MOTHER'S MAIDEN NAME ELLEN LITTLE		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] No	
16. SOCIAL SECURITY NO.		17. INFORMANT Address D. W. WALTER 4 SIXTH STREET, OAKLAND, MD.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 450.1 Chronic Poisoning DUE TO (b) Suppurative Left Foot & Leg DUE TO (c) Arteriosclerosis Obliterans			INTERVAL BETWEEN ONSET AND DEATH 10 hrs
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from Nov 7 , 19 56 , to Nov 21 , 19 56 , that I last saw the deceased alive on Nov 21 , 19 56 , and that death occurred at 8:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED 2500 Cedar St Oakland Md 11/21/56			
ACTUAL SIGNATURE E. L. GARTNER M.D.		PHYSICIAN'S NAME (Type) E. L. GARTNER M.D.	
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	22b. DATE THEREOF Nov-24, 1956	22c. NAME OF CEMETERY OR CREMATORY OAKLAND CEMETERY OAKLAND	22d. LOCATION (City, town, or county) (State) MD.
23. FUNERAL DIRECTOR'S SIGNATURE Emory Baldwin		24a. RECEIVED BY REGISTRAR DATE 11/24/56	

CERTIFICATE OF DEATH

NAME OF DECEASED JOHN W. BROWN		AGE 65		SEX MALE		RACE WHITE		DATE OF DEATH DEC 5 1956		PLACE OF DEATH HOME	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE MYOCARDIAL INFARCTION		DISEASE OR INJURY ANGINA PECTORIS		PERIOD OF ILLNESS 2 WEEKS		PLACE OF BIRTH BALTIMORE, MD	
DATE OF BIRTH NOV 10 1891		PLACE OF BIRTH BALTIMORE, MD		OCCUPATION CLERK		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		SPOUSE'S NAME MARY E. BROWN	
SIGNATURE OF DECEASED JOHN W. BROWN		SIGNATURE OF WITNESS MARY E. BROWN		SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF CLERK JOHN A. JONES		SIGNATURE OF REGISTRAR JOHN A. JONES		SIGNATURE OF DECEASED'S NEAREST RELATIVE MARY E. BROWN	
DATE OF DEATH DEC 5 1956		PLACE OF DEATH HOME		MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE MYOCARDIAL INFARCTION		DISEASE OR INJURY ANGINA PECTORIS	
PERIOD OF ILLNESS 2 WEEKS		PLACE OF BIRTH BALTIMORE, MD		OCCUPATION CLERK		EDUCATION HIGH SCHOOL		MARRIAGE MARRIED		SPOUSE'S NAME MARY E. BROWN	
SIGNATURE OF DECEASED JOHN W. BROWN		SIGNATURE OF WITNESS MARY E. BROWN		SIGNATURE OF PHYSICIAN DR. J. H. SMITH		SIGNATURE OF CLERK JOHN A. JONES		SIGNATURE OF REGISTRAR JOHN A. JONES		SIGNATURE OF DECEASED'S NEAREST RELATIVE MARY E. BROWN	

BUREAU V. S.

DEC 5 1956

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

11378

CERTIFICATE OF DEATH

11367/66
Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY GARRETT MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY GARRETT			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RURAL - OAKLAND				c. LENGTH OF STAY IN 1b RURAL - OAKLAND			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION GARRETT COUNTY MEMORIAL HOSPITAL				d. STREET ADDRESS			
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last WILLIAM CLINTON WELCH				4. DATE OF DEATH Month Day Year NOVEMBER 24 19 56			
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 4-12-1878		9. AGE (In years last birthday) yrs. 78	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) WEST VIRGINIA		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME STILLAS WELCH				14. MOTHER'S MAIDEN NAME ALBRIGHT			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Green a 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio-sclerotic C.R.D. DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH 14 Days 8 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from 11/30 , 19 45 , to 11/24 , 19 56 , that I last saw the deceased alive on 11/24 , 19 56 , and that death occurred at 12:15 P. , from the causes and on the date stated above.							
ACTUAL SIGNATURE Andrew E. Mance M.D.				ADDRESS (Street, city or town, state) Oakland Md DATE SIGNED 24 Nov 56			
PHYSICIAN'S NAME (Type) ANDREW E. MANCE, M. D.				OAKLAND, MARYLAND			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
BURIAL		Nov-27-1956		GORTNER CEMETERY		NEAR OAKLAND MD	
23. FUNERAL DIRECTOR'S SIGNATURE Emory Bolden				ADDRESS OAKLAND MD		24a. REC'D BY REGISTRAR DATE 11/27/56	
						24b. REGISTRAR'S SIGNATURE 2R	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED <i>JOHN J. SMITH</i></p>		<p>2. SEX <i>Male</i></p>		<p>3. AGE <i>45</i></p>		<p>4. DATE OF DEATH <i>Dec 10 1956</i></p>	
<p>5. PLACE OF DEATH <i>Home</i></p>		<p>6. CAUSE OF DEATH <i>Heart Disease</i></p>		<p>7. MANNER OF DEATH <i>Natural</i></p>		<p>8. SIGNATURE OF PHYSICIAN <i>[Signature]</i></p>	
<p>9. SIGNATURE OF REGISTRAR <i>[Signature]</i></p>		<p>10. SIGNATURE OF WITNESS <i>[Signature]</i></p>		<p>11. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>12. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>13. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>14. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>15. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>16. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>17. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>18. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>19. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>20. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>21. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>22. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>23. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>24. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>25. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>26. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>27. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>28. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>29. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>30. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>31. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>32. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>33. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>34. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>35. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>36. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>37. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>38. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>39. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>40. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>41. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>42. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>43. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>44. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>45. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>46. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>47. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>48. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>49. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>50. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>51. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>52. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>53. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>54. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>55. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>56. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
<p>57. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>58. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>59. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>60. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	
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<p>97. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>98. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>		<p>99. SIGNATURE OF DECEASED <i>[Signature]</i></p>		<p>100. SIGNATURE OF SURVIVOR <i>[Signature]</i></p>	

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

11379

CERTIFICATE OF DEATH

11368

Reg. Dist. No. 166

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Garrett</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Garrett</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR			
TOWN <u>Oakland</u>				TOWN <u>Friendsville</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cuppert Nursing Home</u>				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>Emma</u> (Middle) <u>Susan</u> (Last) <u>Wilson</u>				(Month) <u>11</u> (Day) <u>30</u> (Year) <u>19</u> <u>56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday yrs.	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Female</u>	<u>White</u>	<u>Widowed</u>	<u>August 16, 1861</u>	<u>95</u>	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>Housewife</u>		<u>Home</u>		<u>Maryland</u>		<u>U.S.A.</u>	
13. FATHER'S NAME <u>Frank Friend</u>				14. MOTHER'S MAIDEN NAME <u>Mary Friend</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. (If Yes, give war or dates of service)		17. INFORMANT & ADDRESS <u>Mrs. Ada Lee, Masontown, Pa.</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <u>Informatics of Age</u>				INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov 29, 1956</u> to <u>Nov 30, 1956</u> , that I last saw the deceased alive on <u>Nov 29, 1956</u> , and that death occurred at <u>8:30 A.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Arthur F. Jones</u>				DATE SIGNED <u>Nov. 30, 1956</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>				24. REC'D BY REGISTRAR <u>Julia Rowan L.R.</u>			
DATE THEREOF <u>12/2/1956</u>				NAME OF CEMETERY OR CREMATORY <u>Friendsville Cemetery</u>			
25. FUNERAL DIRECTOR'S SIGNATURE <u>Jack Friend</u>				LOCATION (City, town, or county) <u>Friendsville, Md.</u>			

CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD.

FILE NO. 100

1. DECEASED'S NAME (Last, First, Middle)

2. SEX (Male or Female)

3. AGE (Years, Months, Days)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. MARITAL STATUS

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF PHYSICIAN

13. SIGNATURE OF CORONER

14. SIGNATURE OF REGISTRAR

15. SIGNATURE OF CLERK

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF SHERIFF

19. SIGNATURE OF SHERIFF'S DEPUTY

20. SIGNATURE OF SHERIFF'S CLERK

21. SIGNATURE OF SHERIFF'S DEPUTY CLERK

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CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>				c. LENGTH OF STAY IN 1b <u>2 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Mt. Lake Park,</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Evans Nursing Home</u>				d. STREET ADDRESS			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <u>Nelson Robert Wood</u>				4. DATE OF DEATH Month Day Year <u>November 10, 19 56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 4, 1884</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Mine Foreman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>W. Va. Coal Mines</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Joseph Wood</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Murphy</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>214 05 4723</u>		17. INFORMANT Address <u>Mrs. Bertha Wood Mt. Lake Park, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis + Cerebral Hemorrhage</u> DUE TO (c) <u>Senility</u>							INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>9:30P</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Charles E. Smith</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED <u>Terra Alta W. Va. 11/10/56</u>			
PHYSICIAN'S NAME (Type) <u>Charles E. Smith, M. D.</u>				<u>Terra Alta, W. Va.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/13/1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Oakland Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Oakland, Maryland.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Herbert C. Leighton</u>				ADDRESS <u>Oakland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>11/13/56</u>	
24b. REGISTRAR'S SIGNATURE <u>J. R. [Signature]</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

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